Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHSIDE PAIN RELIEF CENTER
3033 FANNIN ST
HOUSTON TX 77004

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-10-3827-01

MFDR Date Received

APRIL 30, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Neither a payment nor denial was received for these services. Via e-mail with a representative, it was stated the bills were denied per lack of authorization. These services were pre-authorized. The bills were submitted in a timely fashion along with the pre-authorization letter."

Amount in Dispute: $601.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier, or its agent, did not respond to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 1, 2009 May 4, 2009	Physical Therapy Services	$601.20	$453.80

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization.
3. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Neither party submitted EOBs for the disputed dates of service. The requestor did submit an email from Customer Service at Universal SmartComp stating "Both DOS were denied back in June of '09 for prior authorization is required.

Issues

1. Did the requestor obtain preauthorization for the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(c), effective May 2, 2006, "the carrier is liable for all reasonable and necessary medical costs relating to the health care:(1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care…." In accordance with 28 Texas Administrative Code §134.600(p) "non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPC)…" The requestor submitted a Texas Outpatient Authorization Recommendation, dated April 27, 2009 from GENEX Services, Inc. approving physical rehabilitation for 20 visits starting April 22, 2009 through July 21, 2009.
2. Per 28 Texas Administrative Code §134.203(b)(1) for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. Review of the documentation submitted by the requestor finds that the treatment rendered to the injured employee meets the requirements of §134.203(b)(1).

   28 Texas Administrative Code §134.203(c) states, in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications (1) … For surgery when performed in a facility setting, the established conversion factor to be applied is $66.32… (2) Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The MAR for the payable services may be calculated by (2009 TDI-DWC MEDICARE CONVERSION FACTOR) x Facility Price = MAR.

   - CPT Code 97110 – (53.68 ÷ 36.0666) x $28.48 x 6 units = $254.33
   - CPT Code 97112 – (53.68 ÷ 36.0666) x $29.07 x 2 unit = $86.53
   - PT Code 97035 – (53.68 ÷ 36.0666) x $11.74 x 2 unit = $34.95
   - CPT Code 97140 – (53.68 ÷ 36.0666) x $26.20 x 1 unit = $77.99

   Review of the submitted documentation finds that the services were rendered as billed; therefore, reimbursement is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $453.80.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $453.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 3, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.